RAND HEALTH

Transparency: A Framework & Some Evidence

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Gaps Exist in Quality for Adults, Children, and Adolescents

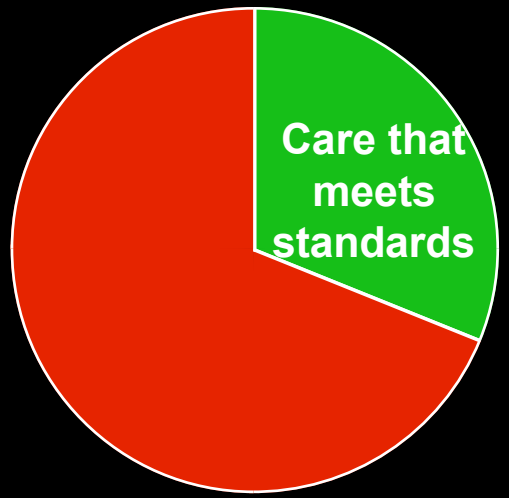
Adults

McGlynn et al 2003;
Mangione-Smith et al, in preparation

Care for Geriatric Conditions Is Poorer Than Care for General Medical Conditions

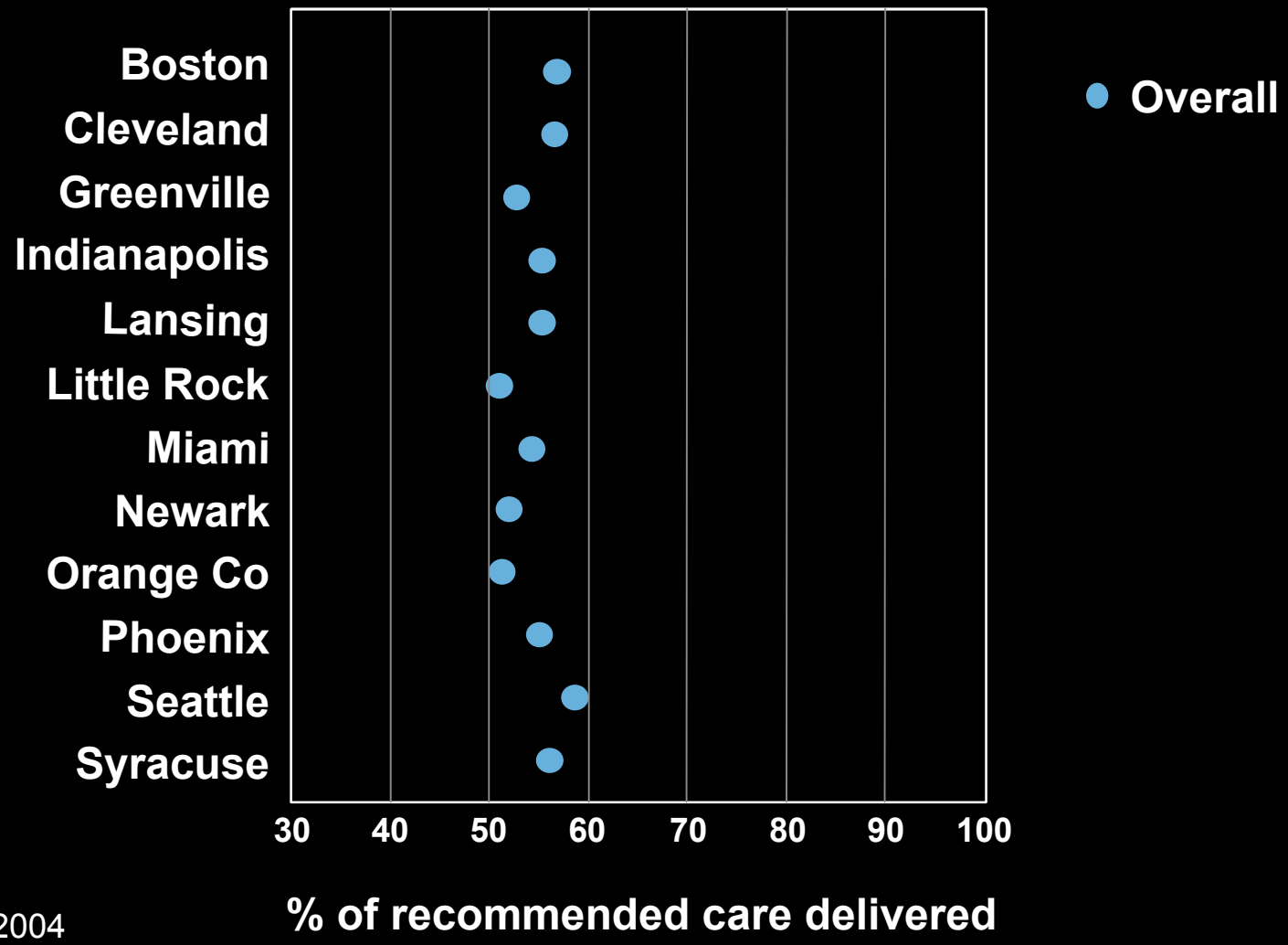
Medical conditions

Geriatric conditions



Wenger et al. (2003)

And You Aren't Safe Anywhere…



Kerr et al., 2004

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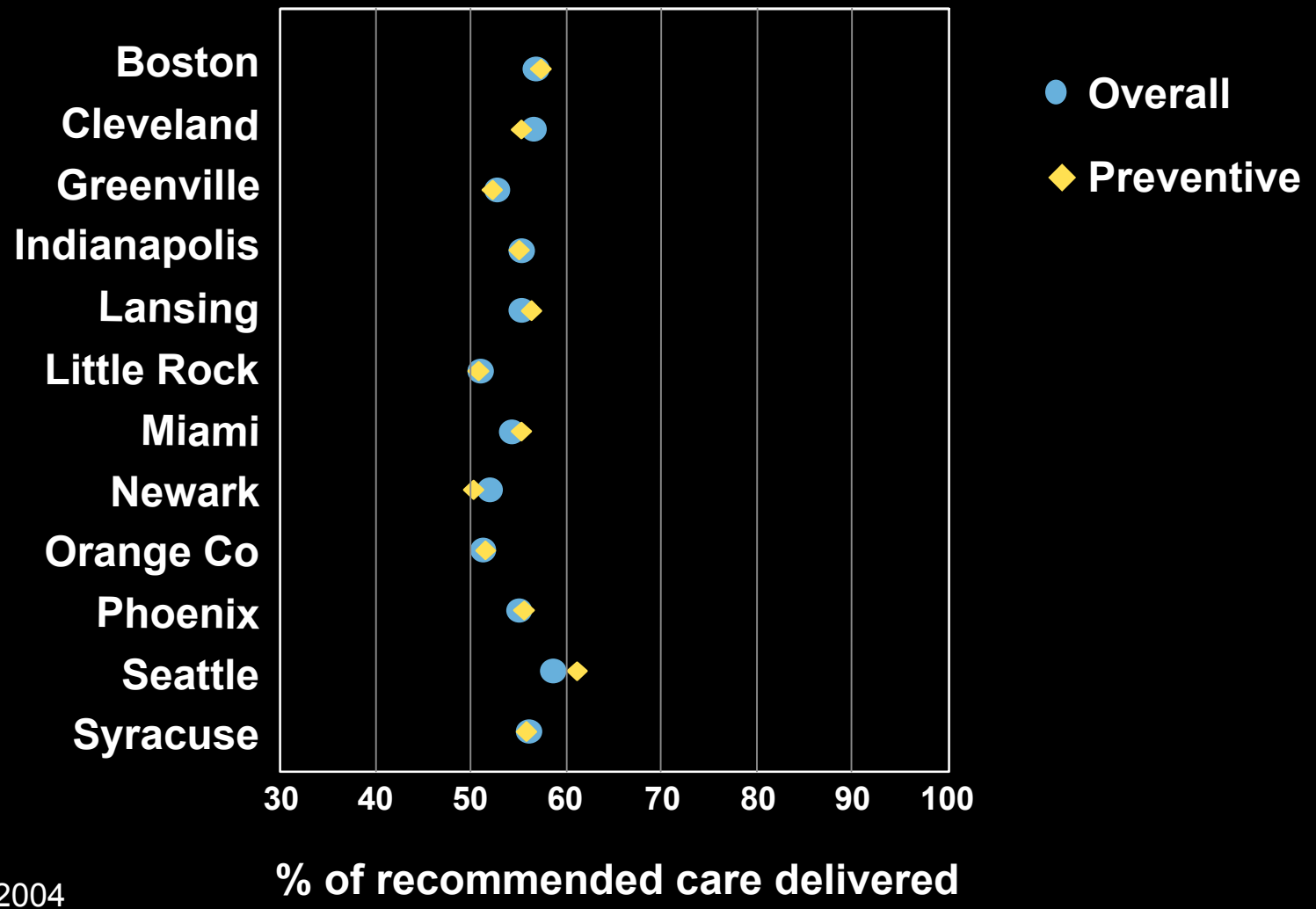

Kerr et al., 2004

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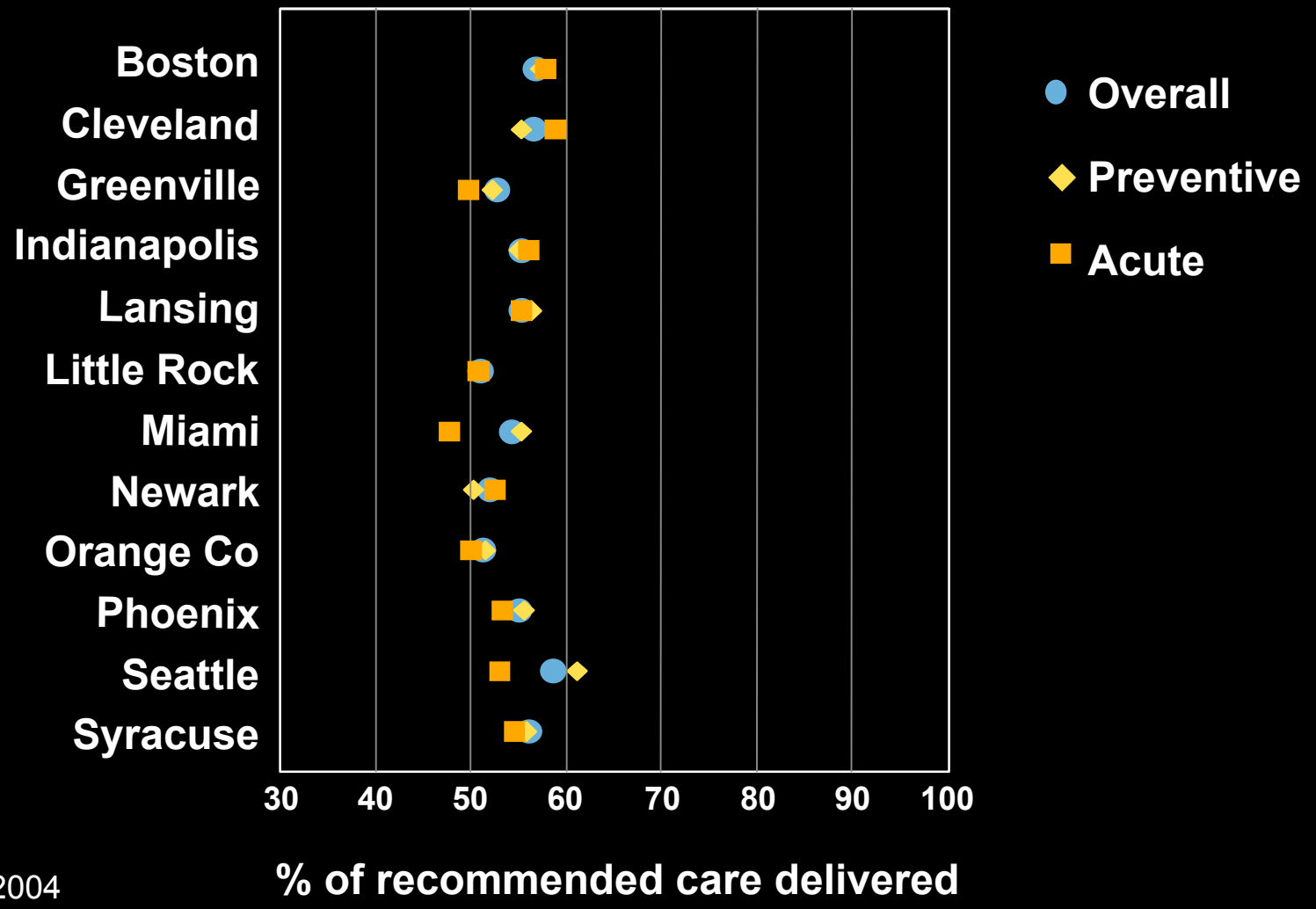

Kerr et al., 2004

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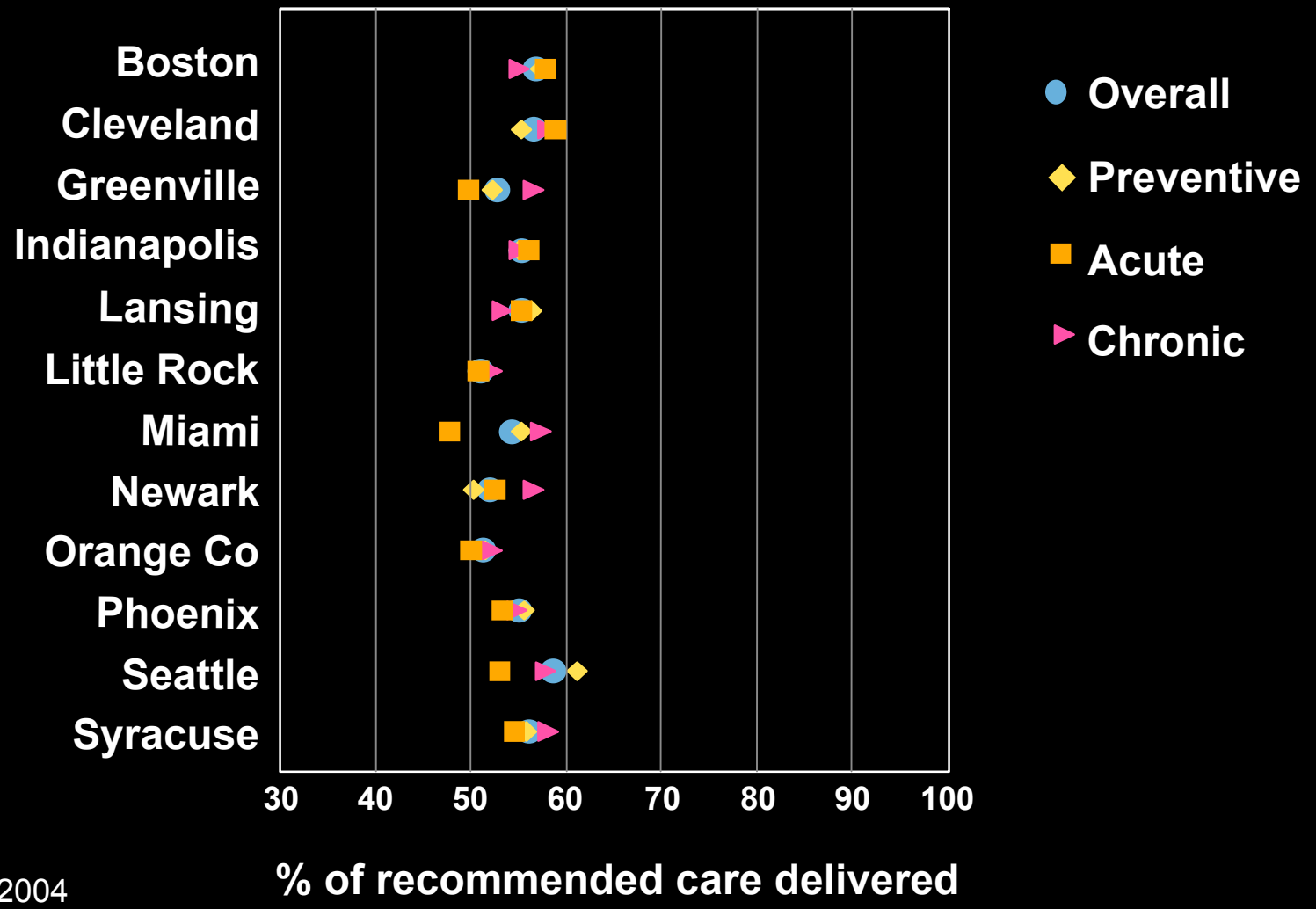

Kerr et al., 2004

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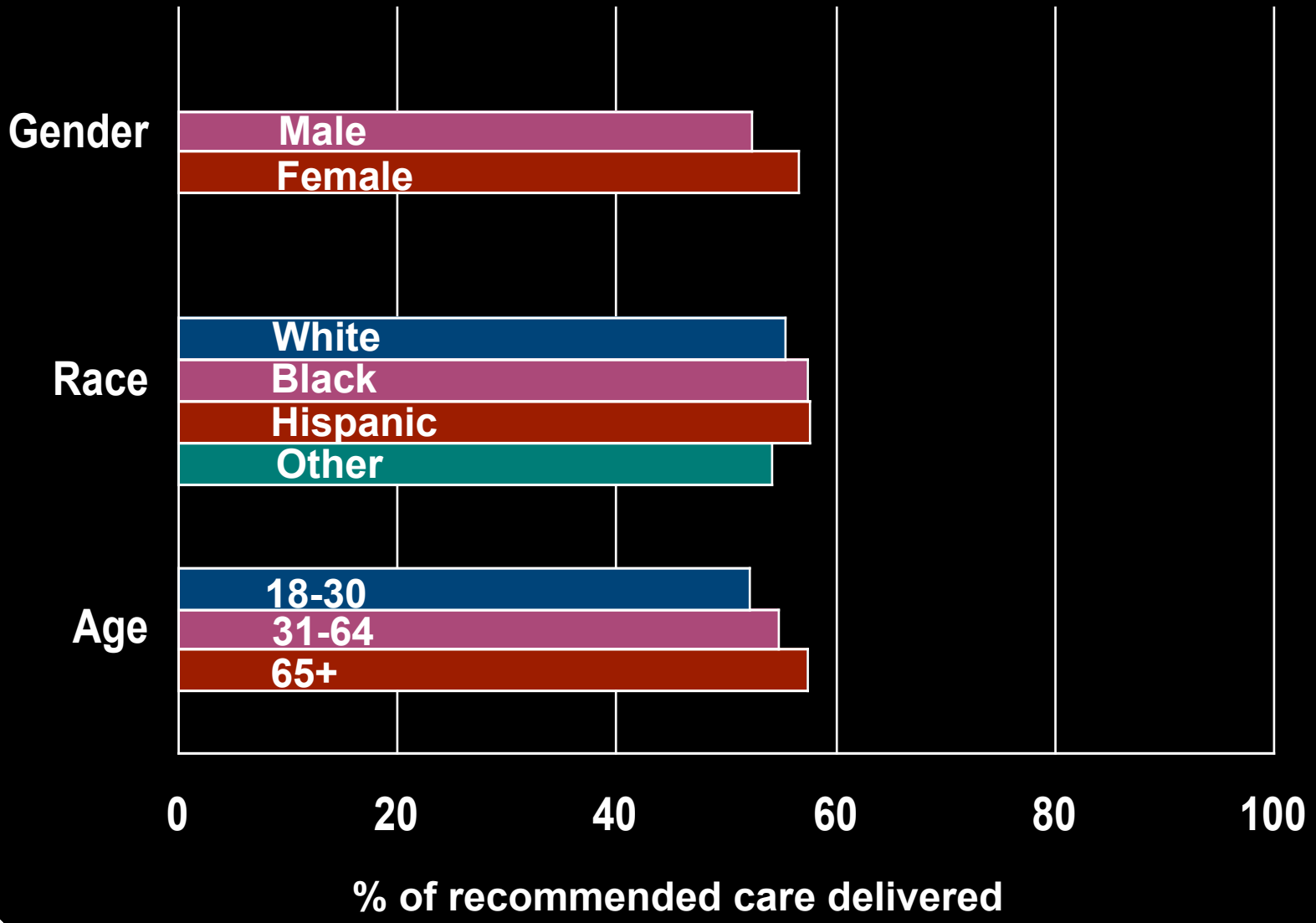
No One Is Immune From Quality Deficits



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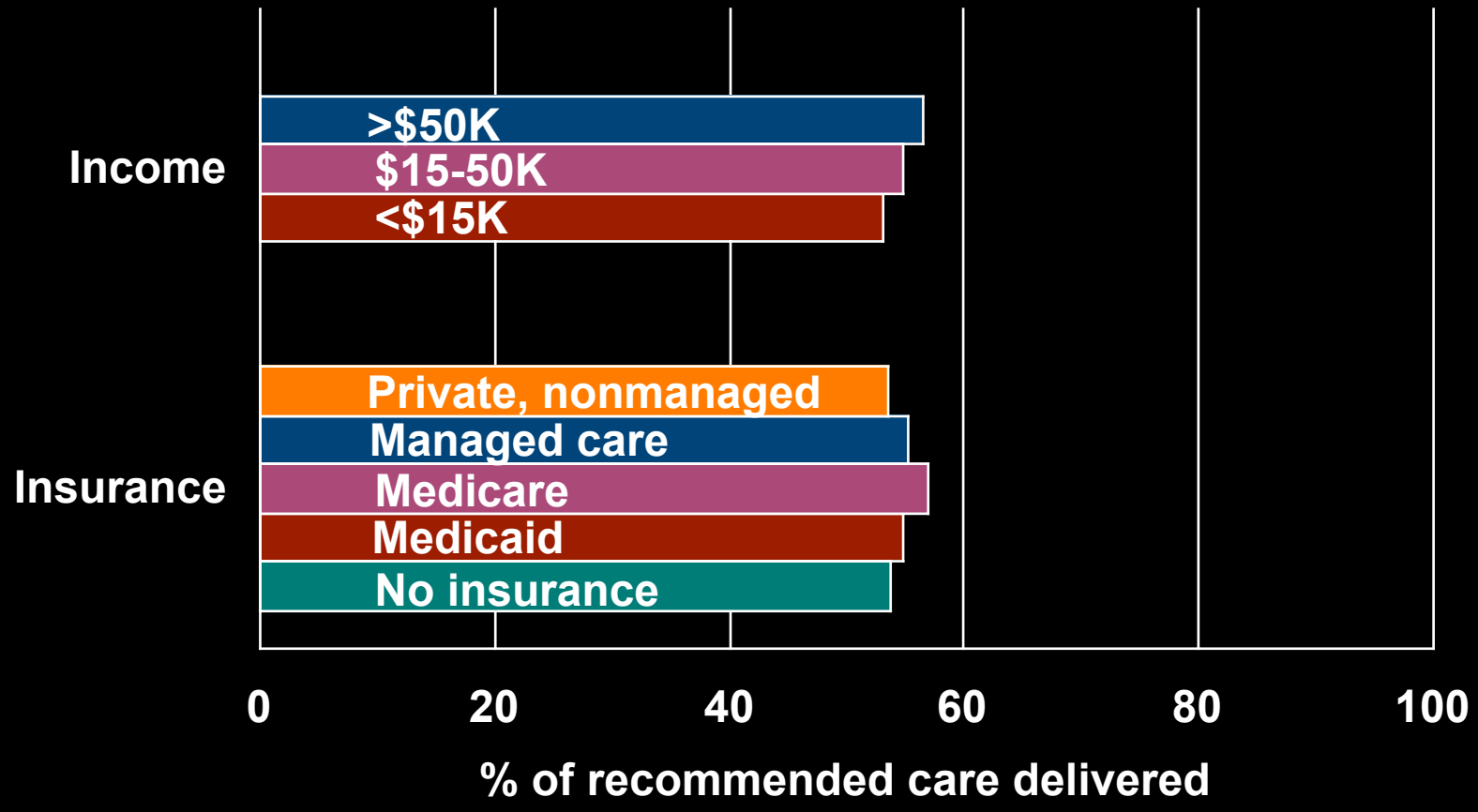
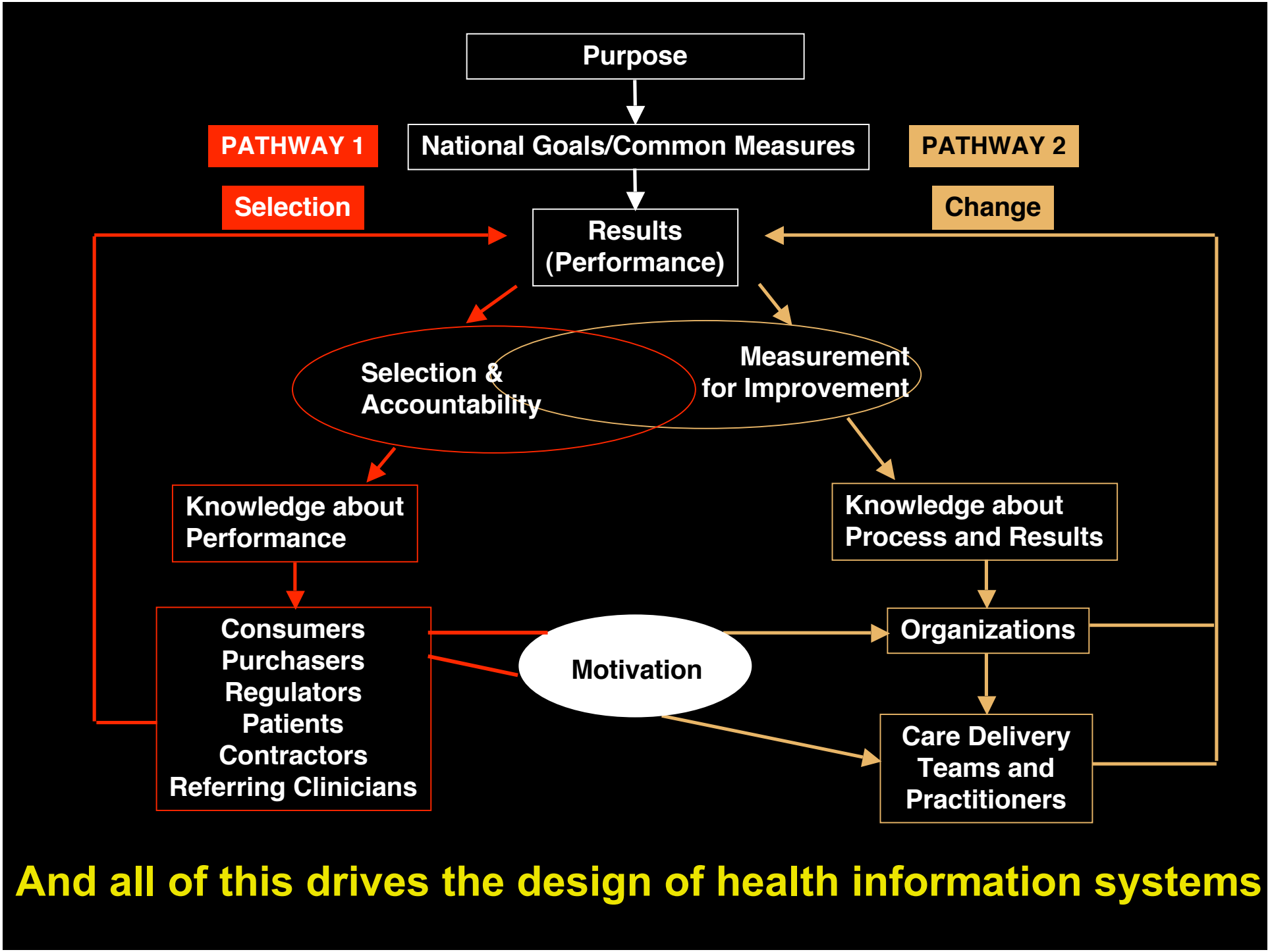
Money Doesn't Buy Quality



Transparency Is Promoted As A Key Tool For Quality Improvement

- If you don't know how you are doing it is difficult to improve
- If patients are putting their lives in your hands, it is reasonable for them to be aware of the risks
- Information offers an opportunity to learn from others about best practices


Purpose
National Goals/Common Measures
PATHWAY 1
PATHWAY 2
Selection
Change
Results
(Performance)
Selection &
Accountability
Measurement
for Improvement
Knowledge about
Performance
Knowledge about
Process and Results
Consumers
Purchasers
Regulators
Patients
Contractors
Referring Clinicians
Motivation
Organizations
Care Delivery
Teams and
Practitioners
And all of this drives the design of health information systems

Quality Measures Promulgated by Multiple Organizations

Quality Domain	Organizations	Example
Effective	HQA, JCAHO, CMS, NQF, Health Plans, NCQA, IHI, Vendors	Beta blockers after heart attack
Safe	Leapfrog, JCAHO	Hand hygiene, procedure volume
Patient-Centered	CAHPS, CHART, Press Ganey	Recommend this hospital
Efficient	Health Plans, Large employers	Relative charges for bypass surgery
Equitable	AHRQ	Mortality rates for blacks vs. whites
Timely	CAHPS, CHART, CMS	Delays in getting care, Door to PCI

Performance Information Being Used In Different Ways

- Media reports
- Participation in reporting linked to update factor for Medicare reimbursement
- Health plans using data in pay-for-performance programs, contracting
- CMS, JCAHO publicly reporting results
- Private vendors report results
- Large employers structuring benefit packages around performance metrics
- Private organizations creating campaigns

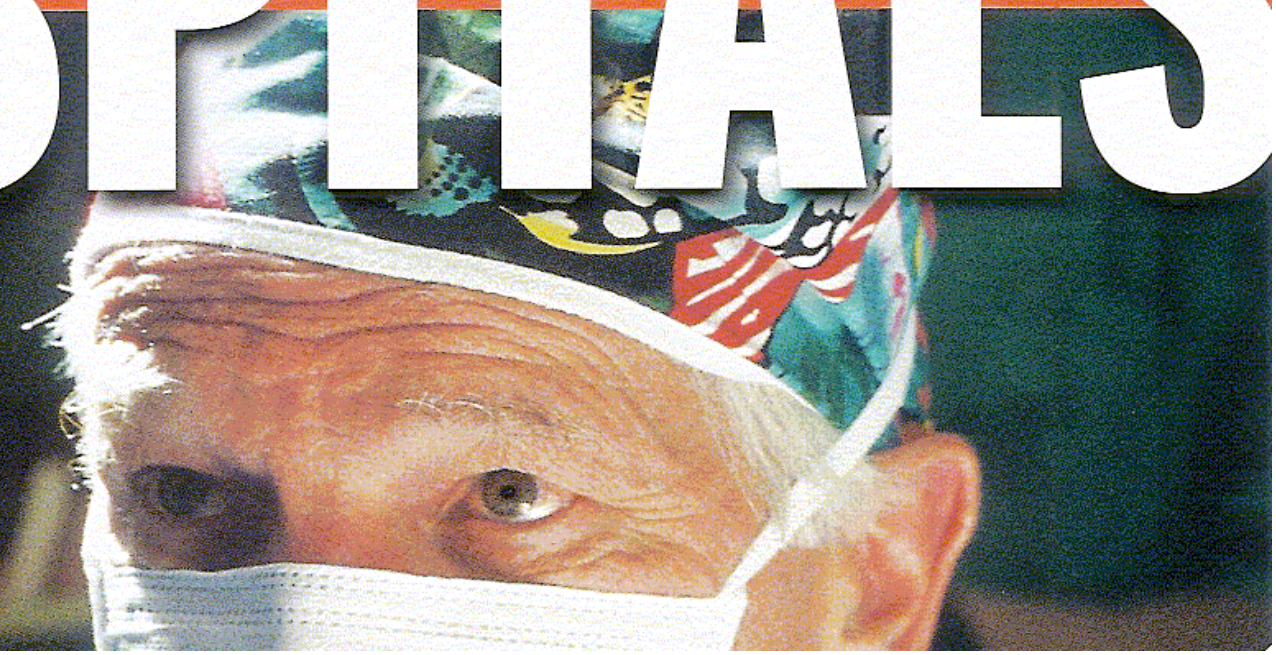
U.S.News & WORLD REPORT

JULY 22, 2002

www.usnews.com

AMERICA'S BEST HOSPITALS

EXCLUSIVE RANKINGS IN 17 KEY SPECIALTIES



RAND Has Recently Reviewed the Evidence on the Effects of Public Reporting

- Fung, Lim, Mattke, Damberg & Shekelle (2006 draft white paper)
- Reviewed 50 articles published since 1986
  - 10 evaluated the New York State Cardiac Reporting System
  - Most studies were observational or qualitative
    - 2 randomized trials

What Do We Know About the Effect of Public Reporting on Selection?

- **Identified 22 studies examining effects on selection**
  - **Results are mixed**
    - **10 positive findings (9 post-1999)**
    - **12 null or negative findings (7 post-1999)**

The New York Times

MONDAY, SEPTEMBER 6, 2004

Clinton Surgery Puts Attention On Death Rate

By LAWRENCE K. ALTMAN

The hospital where former President Bill Clinton awaits bypass surgery in the next few days has the highest death rate for the operation in New York State, according to the state's Health Department. While the death rate is quite low — less than 4 percent of all bypass operations — it is still nearly double the average for hospitals in the state that perform bypasses.

The Clinton family had no comment on the Health Department's statistical profile, which showed that the hospital, Columbia-Presbyterian Center of New York Presbyterian Hospital, where Mr. Clinton, 58, has been a patient since early Friday, had a 3.93 percent overall death rate for coronary bypass surgery in 2001, the latest year for which data were

Clinton Hospital's Death Rate Is Higher for Bypass Surgery

Continued From Page A1

ity of illness among patients, the state of patients' health before the operation, the skill of the operating team and general post-operative care after the surgery - to arrive at risk-adjusted death rates for all the hospitals.

The state uses several statistical measures and adjusts the overall statistics to account for about 45 risk factors — like differences in the severity of illness among patients, the state of patients' health before the operation, the skill of the operating team and general postoperative care after the surgery — to arrive at risk-adjusted death rates for all the hospitals.

Columbia-Presbyterian and Westchester County Medical Center were the only two hospitals in the state that had risk-adjusted death rates that were significantly higher than

The hospital has a strong reputation for teaching and care.

they often change, as they did for the two hospitals. In 2000, when the overall statewide rate was 2.32 percent, the rates for Columbia-Presbyterian and Westchester County Medical Center were within the usual range, at 2.24 and 2.91, respectively.

The two hospitals with the most favorable rates in 2001 were Staten Island University-North and New York Weill Cornell Center in Manhattan. Their risk adjusted rates were 0.34 percent and 0.95 percent, respectively, compared with that of the state.

The state also provides specific death rates for each surgeon performing coronary bypass operations.

Mr. Clinton, his family and the hospital have provided few details about the impending surgery and have not publicly identified the surgeons who will perform the bypass.

The state's death statistics cover bypass patients who die in the hospital during or anytime following surgery. If a patient is discharged from the hospital, his death is reflected in the statistics if it occurs within 30 days of the procedure.

One reason for the two-year delay in providing the figures is that the state has to await information about deaths of patients who were operated on in New York but died elsewhere, said Dr. O. Wayne Isom, the vice chairman of the committee that ad-

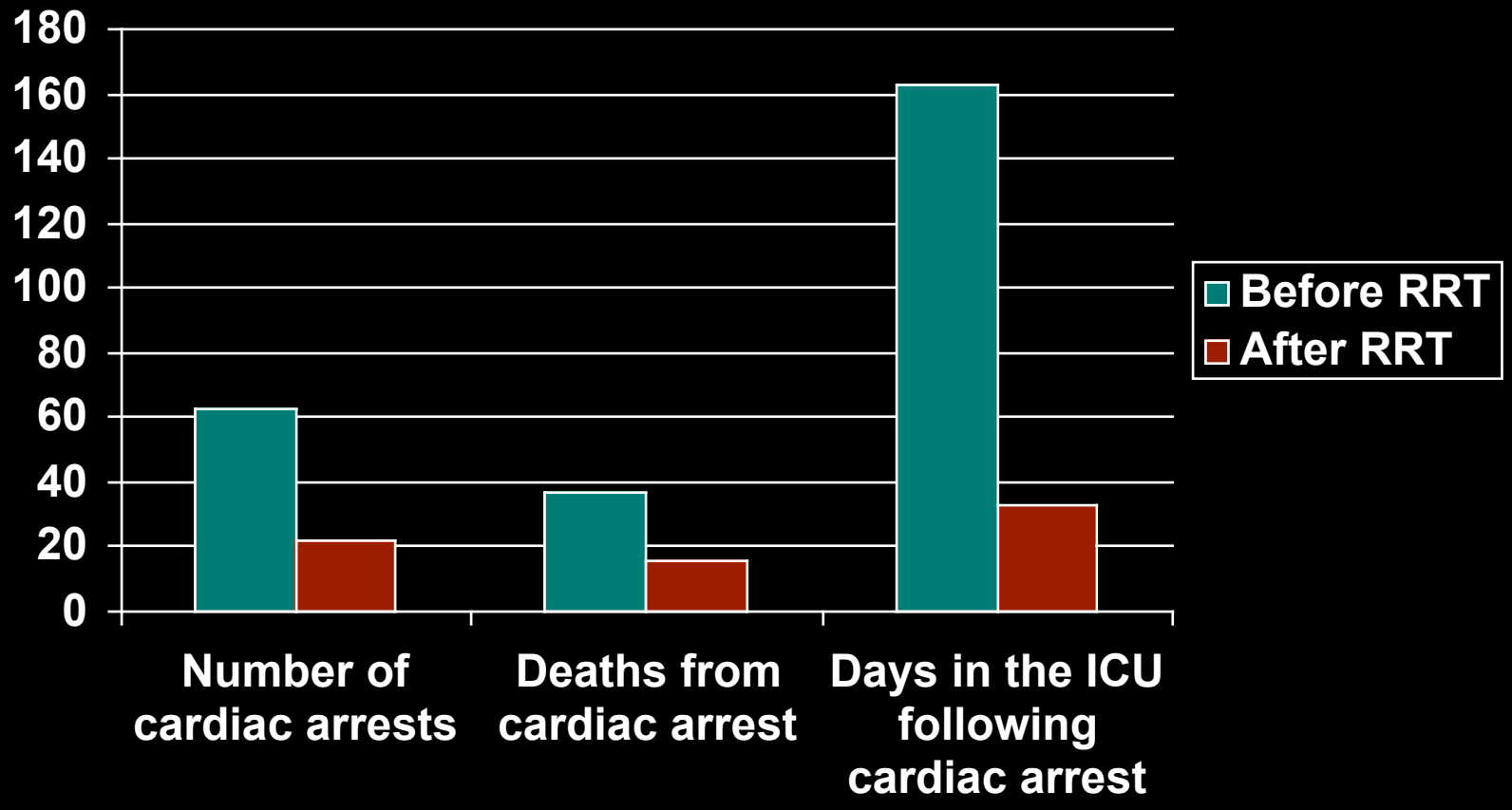
What Do We Know About the Effect of Public Reporting on Change?

- **Reviewed 10 studies evaluating the effect on change**
  - **Results are favorable**
    - **8 report positive results (4 post-1999)**
    - **2 report negative results (both pre-1999)**

Overview of the Institute for Healthcare Improvement 100,000 Lives Campaign

Practice	Description
Rapid Response Teams	Team deployed to respond to changes in patient status
Reliable heart attack care	Bundle of 6 evidence-based practices
Prevent ventilator acquired pneumonia	Bundle of 5 best practices
Prevent adverse drug events	Maintain current list of medications for all patients all the time
Prevent surgical site infection	Use of 4 best practices
Prevent central line associated bloodstream infection	Bundle of 5 best practices

Rapid Response Teams Are Effective in Reducing Mortality Outside of the ICU

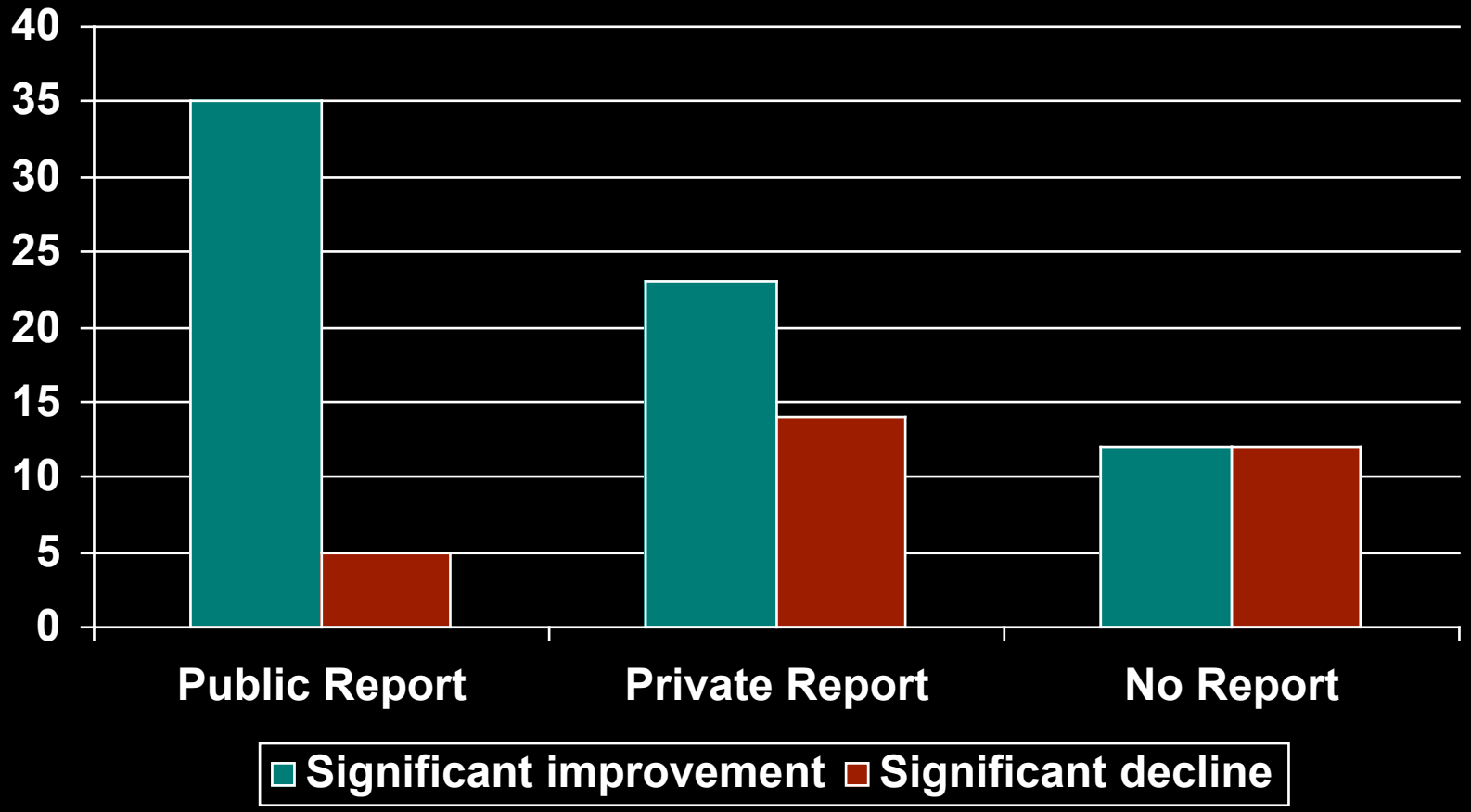


Bellomo R, et al. MJA 2003;179:283-287

What Do We Know About the Effect of Public Reporting on Performance?

- **11 studies examined the effect of reporting on effectiveness, safety, patient-centeredness**
  - **5 positive (4 pre-1999)**
  - **6 negative or null (4 post-1999)**
- **Also, 10 studies published that reported unintended (negative) consequences**

Wisconsin Hospitals Randomized to Public Reports Showed Greatest Improvement



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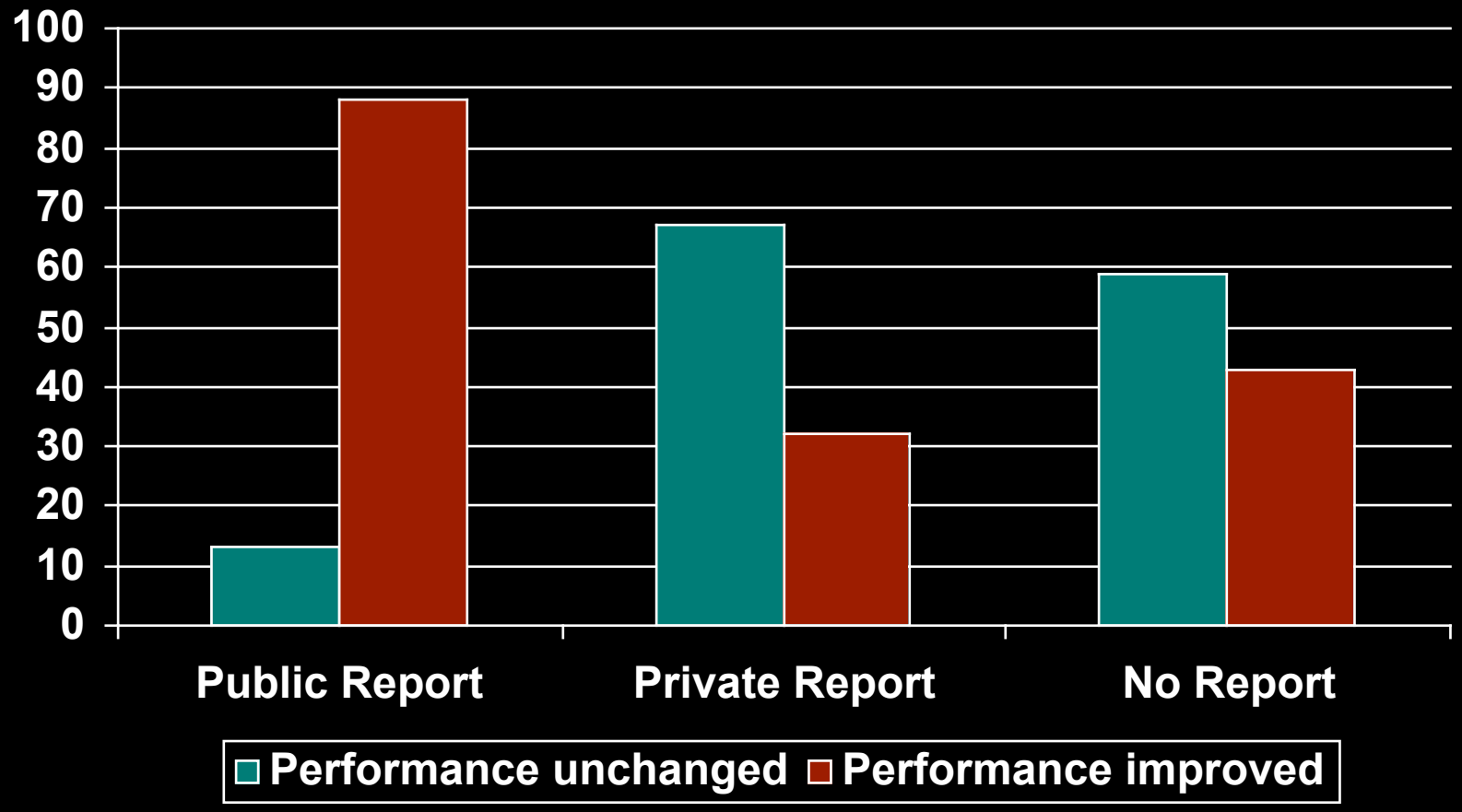
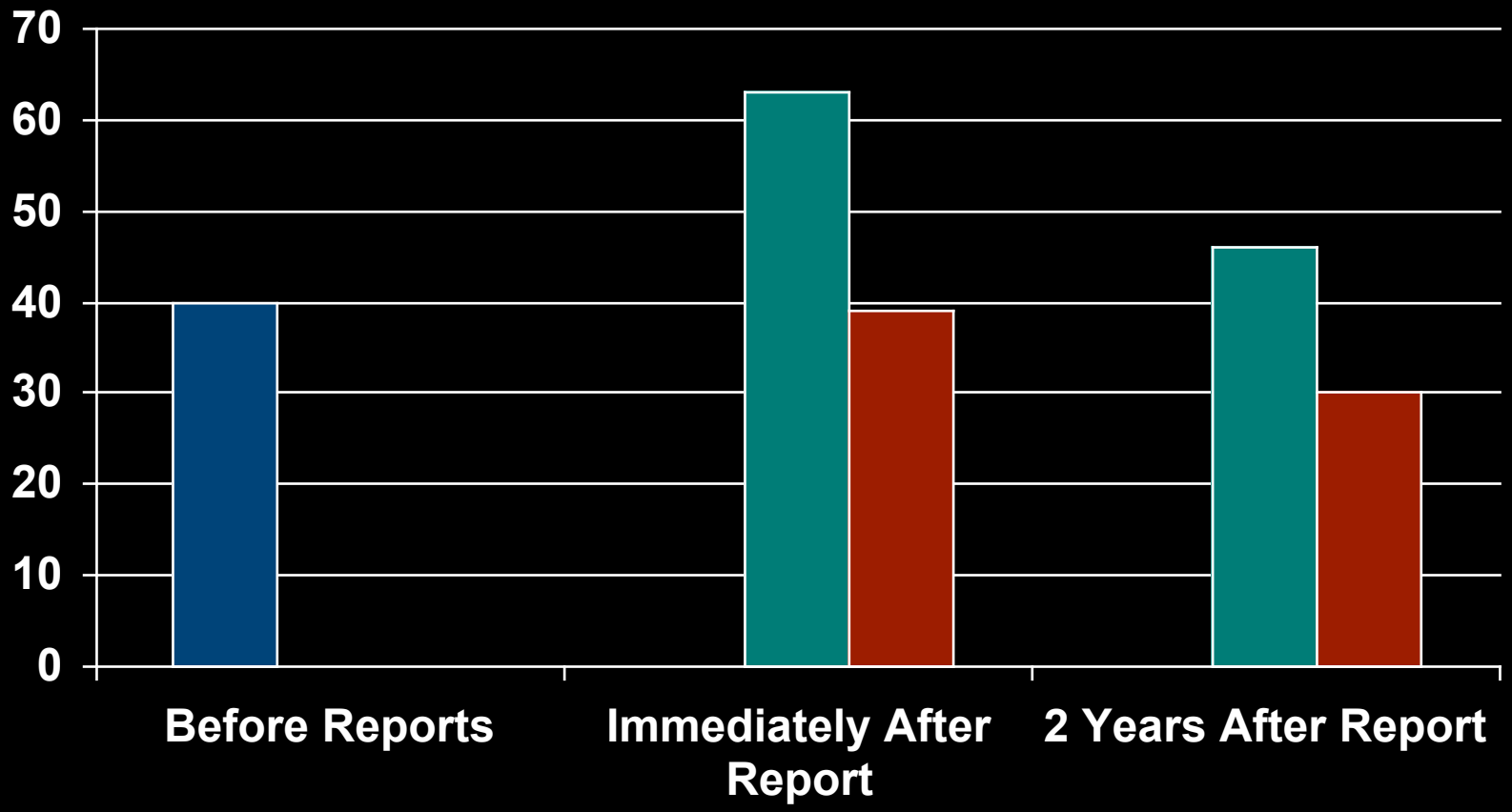
Hibbard et al 2005

Greater Improvement for Low Performers at Baseline with Public Reports



Hibbard et al 2005

Proportion of Consumers Correctly Identifying Poor Performing Hospitals



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Hibbard et al. 2005

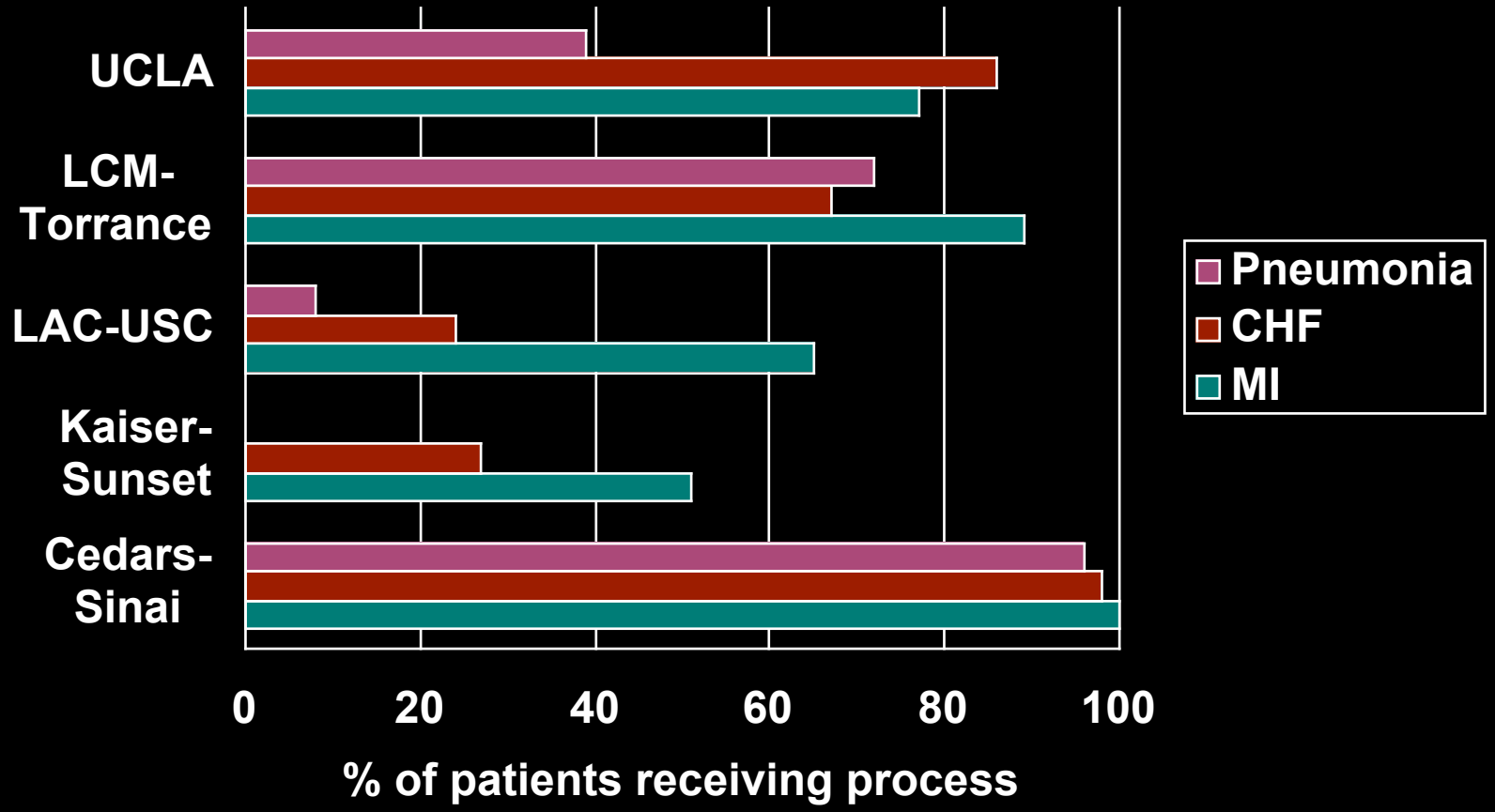
What Additional Research Is Needed?

- A larger number of different types of organizations and reporting systems should be evaluated
  - Rigorous evaluation strategies should be used
- More careful attention to the approaches that increase the likelihood of successful uptake
  - Formatting
  - Availability
  - Framing
- Develop a more refined model for effectively using transparency

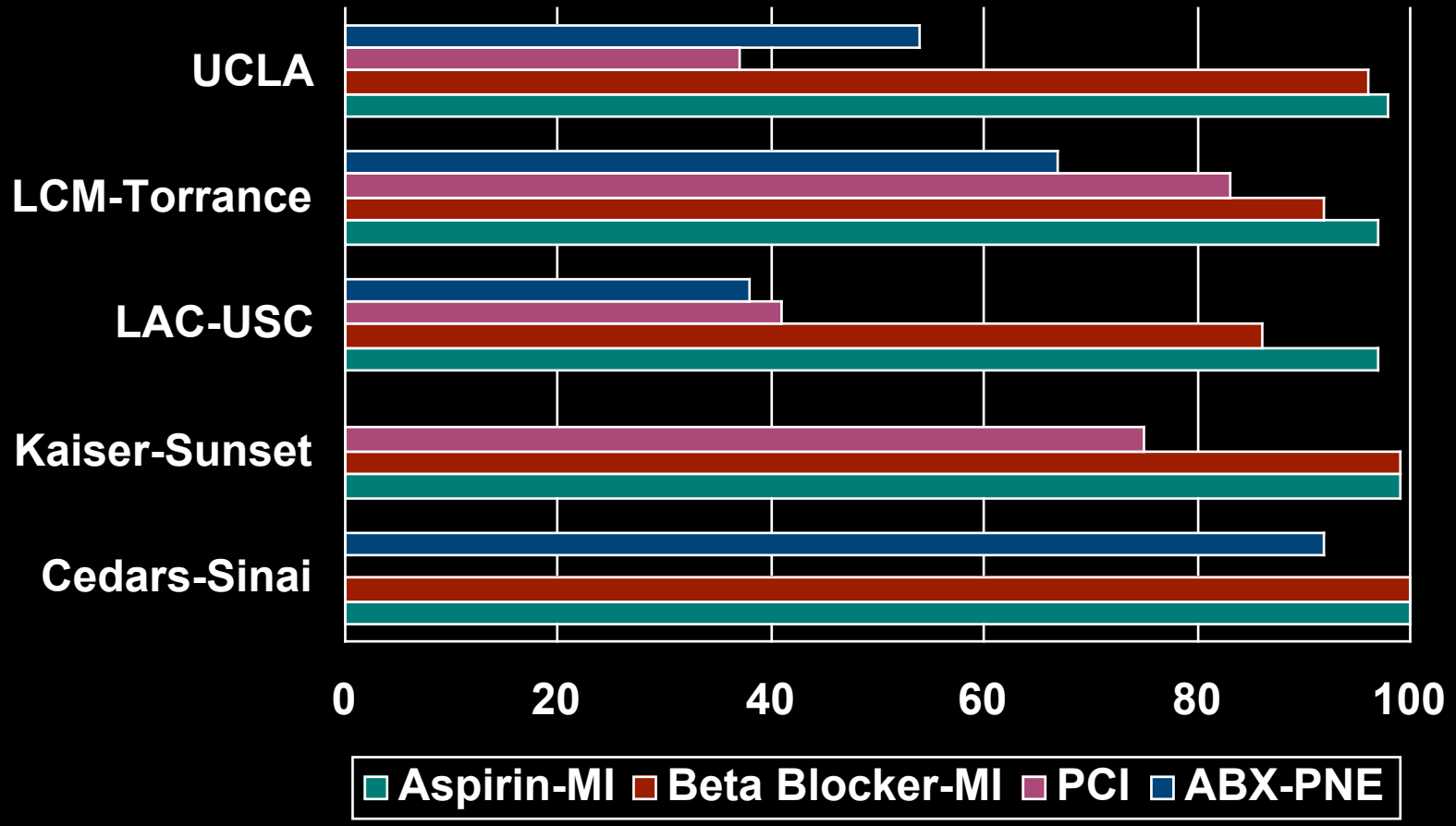
So, What Do We Do While We Wait?

- Collaborate to produce a common set of measures and reporting formats
  - Multiple, competing/conflicting sources of information more likely to confuse than elucidate
- Identify sets of measures that illuminate systems problems and solutions

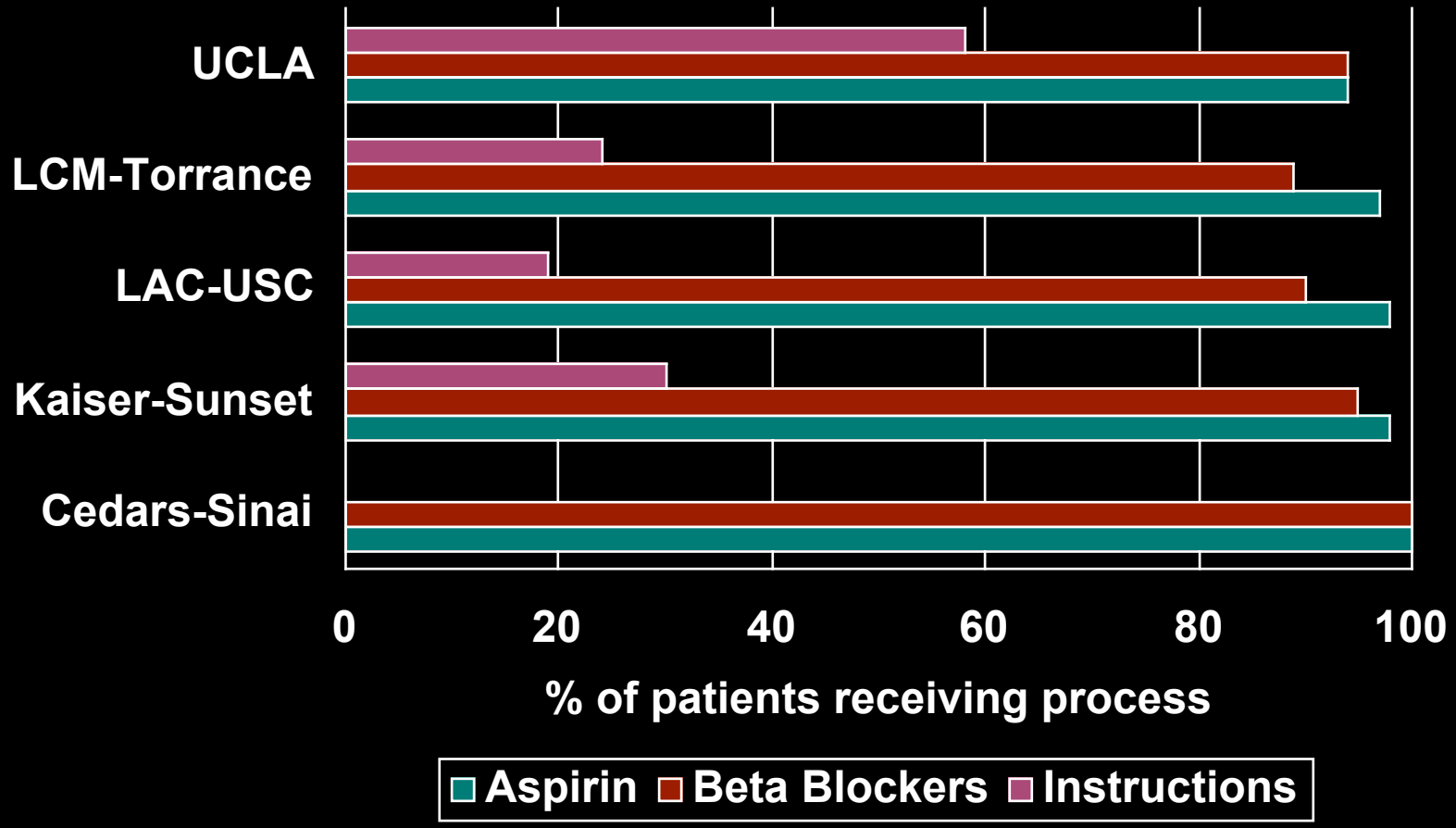
The Unreliability of Smoking Cessation Counseling



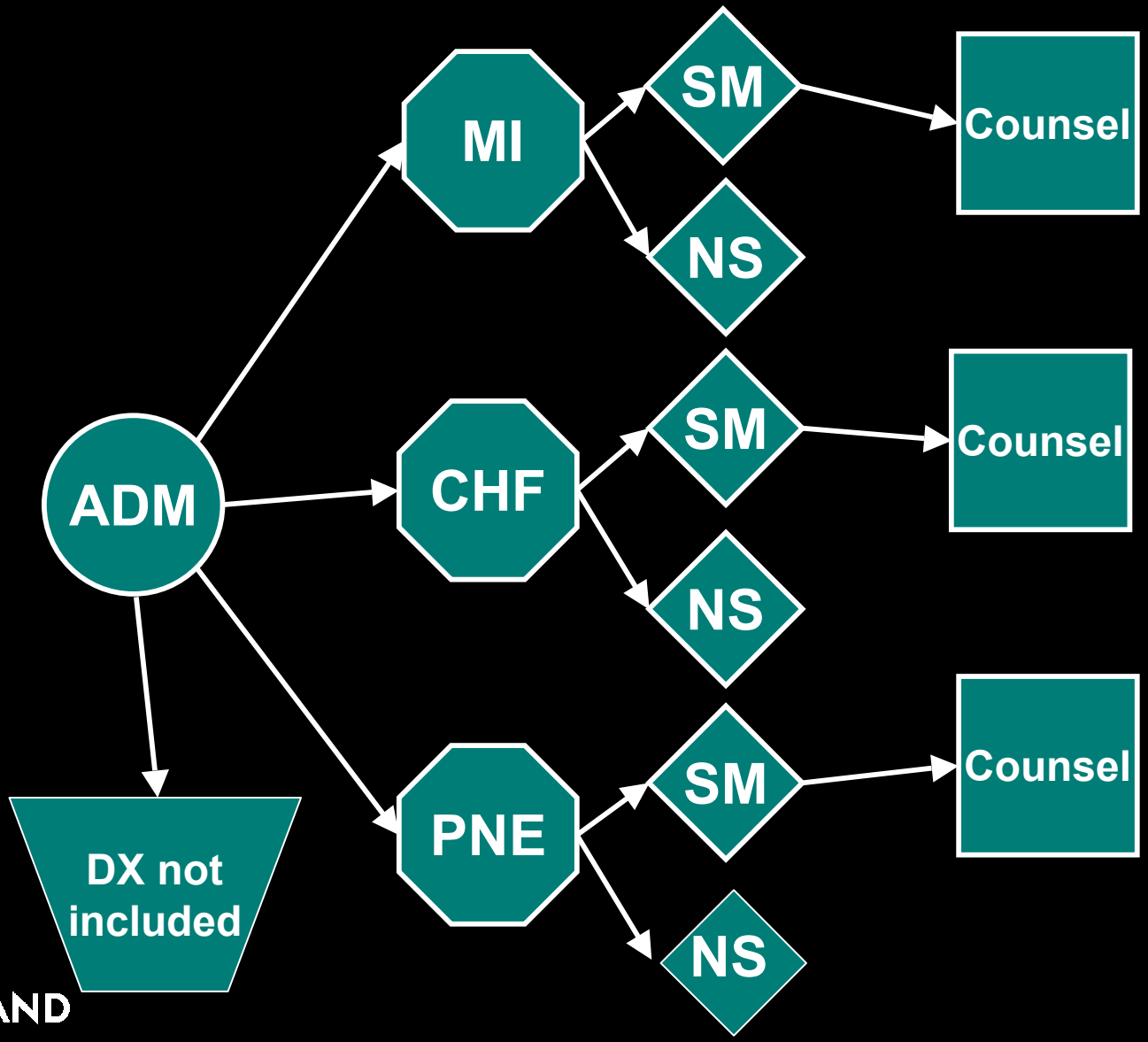
Lack of Reliability in Timely Administration of Therapy



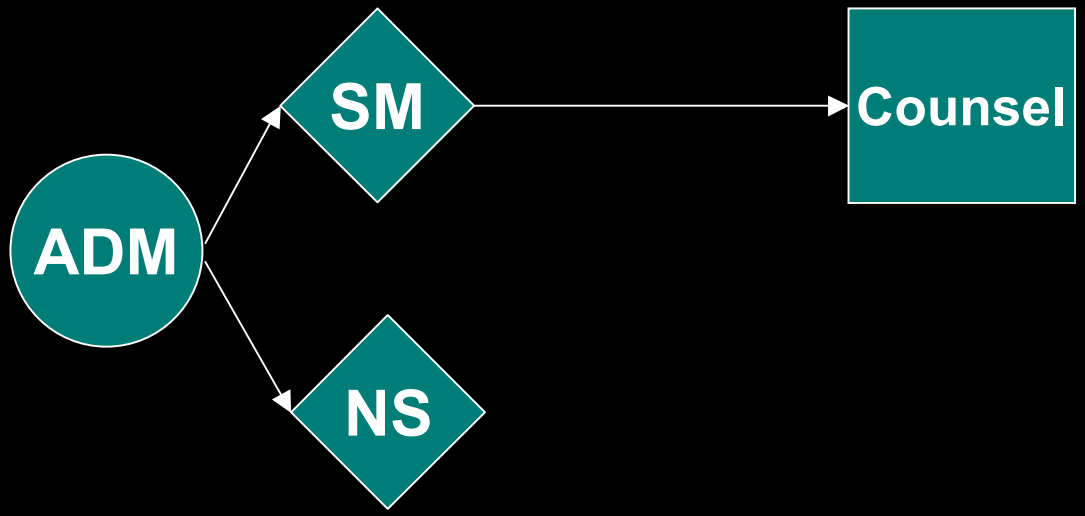
Differential Reliability at Discharge



Organizing to Deliver Measure-Based Care



Reliable Systems Usually Have Fewer Steps



What other processes should look like this?

So, What Do We Do While We Wait?

- Collaborate to produce a common set of measures and reporting formats
  - Multiple, competing/conflicting sources of information more likely to confuse than elucidate
- Identify sets of measures that illuminate systems problems and solutions
- Link the measures to clearly articulated goals for performance and improvement
- Provide tools for providers and patients to facilitate improvement and dialogue

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